## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBER  396149  NAME OF PROVIDER OR SUPPLIER: ADVANCED CARE CENTER OF BUTLER  STATE LICENSE NUMBER: 50690201		STREET ADDRESS,	(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00 B. WING:  CITY, STATE, ZIP CODE:  BLOGY DRIVE  16001		(X3) DATE SURVEY COMPLETED: 06/30/2023		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE			FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTII	LSC PREFIX TAG		CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE DATE	
F 0000	Based on a Revisit survey completed on June 30, 2023, at Advanced Care Center of Butler, it was determined that the facility corrected the deficiencies cited during the survey of May 12, 2023, under the requirements of 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.		F 0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

CMS-2567L KKQ012 IF CONTINUATION SHEET Page 1 of 1



## **Certified End Page**

## ADVANCED CARE CENTER OF BUTLER

STATE LICENSE NUMBER: 50690201 SURVEY EXIT DATE: 06/30/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

## **PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY